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An Examination of the Use of Advance Directives at Naval Hospital Bremerton

A Graduate Management Project Submitted in Partial Fulfillment of Requirements for the Degree of Master of Health Administration

April 2005

By

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Abstract

This retrospective, exploratory, qualitative review of 1,976 inpatient charts of patients 18 years or older and hospitalized during fiscal year 2003, examined the recognition of pre-existing advance directives and compliance with patient treatment preferences at the Naval Hospital Bremerton. The study showed that the Naval Hospital Bremerton had 39 completed advance directives on file. An additional 374 patients, 217 female and 157 male, claimed to have executed advance directives, but there were no directives found in the inpatient records. The study also identified patients who expressed a desire to execute an advance directive.

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Introduction

Background

Most of the nation learned about advance directives because of the publicity surrounding a landmark court case that began with the tragic events on an evening in 1983. The woman at the center of the case had spoken with her family and friends about her aversion to being placed on life support and living *like a vegetable;* she never committed these feelings to paper, nor did she discuss her views with her health care providers. Her name was Nancy Beth Cruzan.

Late in the evening of January 11, 1983, while driving down Elm Road in rural Jasper County, Missouri, Nancy was involved in an automobile accident. When rescuers found her lying face down in a ditch, Nancy was not breathing and had no pulse. It was approximately 12 to 14 minutes after she had stopped breathing that the paramedics, who labored to save her at the scene, restored her heartbeat and respiration. This period of anoxia (lack of oxygen to her brain) combined with probable cerebral contusions, left Nancy comatose. After three weeks, her condition improved to a point where although unconscious, she was able to ingest some food orally. In the belief that it would aid her recovery, Nancy's husband authorized the surgical placement of a "gastrostomy feeding and hydration tube" (*Nancy Beth Cruzan by Her Parents & Co-Guardians v. Director*, 1990).

The Cruzan family held out hope that this once vibrant young woman would recover from her injuries, but, as time dragged on, it became clear that Nancy would never regain consciousness. Nancy's injuries had left her in a persistent vegetative state (PVS). Using the definition of Dr. Fred Plum, who coined the phrase persistent vegetative state and is considered an expert on its use, Chief Justice Rehnquist wrote in the Cruzan opinion:

> 'Vegetative state describes a body which is functioning entirely in terms of its internal controls. It maintains temperature. It maintains heartbeat and pulmonary ventilation. It maintains digestive activity. It maintains reflex activity of muscles and nerves for low-level conditioned responses. But there is no behavioral evidence of either self-awareness or awareness of the surroundings in a learned manner" (*Cruzan v. Director*, 1990).

After all rehabilitative efforts were determined to be futile; Nancy Cruzan was transferred to the Missouri Rehabilitation Center. Her family was convinced that she never would have wanted to live in such a condition, but they and her healthcare providers were aware that Nancy was in no imminent danger of dying so long as she received food and water through a surgically implanted tube. It was for this reason that the Cruzan family requested her physicians discontinue Nancy's hydration and nutrition support.

The Rehabilitation Center refused the request, and the Cruzan family sought relief through the courts. The healthcare facility argued that there was a state interest in protecting Nancy's life. The Missouri Living Will Statute, Mo Rev. Stat. § 459.010 et seq. (1986), espoused a state policy favoring the preservation of life, clear and convincing evidence was required of Nancy's intent to refuse death prolonging treatment, such as nutrition and hydration. (*Cruzan v. Director, 1990,* Missouri Revised Statutes, 2004) The Cruzan family argued that Nancy had clearly expressed her opposition to lingering in a vegetative state to both an aunt and a co-worker. It was the family's contention that because a competent Nancy would have refused the feeding tube, the state must permit her to die. (Right-To-die Ruling, 1990)

The U.S. Supreme Court heard arguments in the *Cruzan* case in June 1989. The Justices handed down their opinion in January 1990, and it helped to change the face of healthcare. The Justices said that the state was within its rights to demand clear and convincing evidence in order

to allow a patient to die, but that if such evidence were available, a patient's right to refuse treatment must be respected. The Cruzan family was not granted the immediate relief that it had asked for, but the Supreme Court ruling did provide a pathway for the family to follow.

In August 1990, Lester and Joyce Cruzan petitioned the Probate Court of Jasper County, Missouri for a hearing based on the discovery of new evidence. Three of Nancy Cruzan's former co-workers testified that Nancy had stated, in conversations with them, that she would never want to live in a persistent vegetative state. Judge Charles E Teel, Jr., found that the new testimony met the clear and convincing evidence standard. He stated, "Nancy would want to terminate her nutrition and hydration and that she would not want to continue her present existence, hopeless as it is, and slowly, progressively worsening" (Deaths: Nancy Beth Cruzan, 1990). Judge Teel ordered the removal of the feeding tube. (Nachtigal, 1990).

Less than two hours after the probate court ruled, her physician at the Missouri Rehabilitation Center in Mount Vernon, Missouri removed Nancy's feeding tube. Nancy Beth Cruzan died shortly after three in the morning, on December 26, 1990, at the age of 33 (Gladwell, 1990). Her tombstone has at the top, a picture that resembles an electrocardiograph printout that spells out the words "thank you" and is followed by a flat line to symbolize death. Below the picture are the words, "NANCY BETH CRUZAN, MOST LOVED, DAUGHTER-SISTER-AUNT, BORN JULY 20, 1957, DEPARTED JAN 11, 1983, AT PEACE DEC 26, 1990" (Taub, 2001).

Nancy Cruzan's situation was not a unique one. Justice Brennan, in his dissenting opinion in the *Cruzan* case, said that there were approximately 10,000 individuals who were in a persistent vegetative state and occupying hospital beds throughout the United States in 1990. He also related that the use of advanced resuscitative technologies continues to play a role in

increasing that number. He pointed out that the ability to restart a patient's respiration and heartbeat did result in reviving some patients who recovered fully, but it also helped to maintain the physical life of some who would linger on suspended between consciousness and death. (*Cruzan v. Director*, 1990)

While it is true that some patients want every possible technology used to sustain them, other patients would view being sustained by life support equipment as a living hell. Who is charged with determining what will be done when a patient's medical condition calls for him or her to either be placed on life support or be permitted to die naturally? Each state has specific guidelines as to who is given the task, but there is a legal instrument that can make these decisions a little easier. The patient using an advance directive can answer questions concerning what he or she desires should he or she become unable to participate in medical decision-making.

The term advance directive is a broad one that applies to a document that provides guidance to the health care team in the event that the person is no longer capable of making decisions. Taber's Cyclopedic Medical Dictionary defines an advance directive as, "A document prepared while an individual is alive and competent. It provides guidance to the health care team in the event the person is no longer capable of making decisions" (Taber, 1993, 47). The document can be a living will that outlines specific treatment preferences, a durable power of attorney that designates a surrogate decision maker; instructions concerning organ donation; or a do-not resuscitate order, if requested by the patient.

Although many states had recognized a patient's right to prepare advance directives, the Cruzan case helped to highlight the fact that, as of 1990, few Americans had prepared them. Justice Brennan discussed this in his dissenting opinion on the Cruzan case:

> While it might be a wise social policy to encourage people to furnish such instructions, no general conclusion about a patient's choice can be drawn from the absence of formalities. The probability of becoming irreversibly vegetative is so low that many people may not feel an urgency to marshal formal evidence of their preferences. Some may not wish to dwell on their own physical deterioration and mortality. Even someone with a resolute determination to avoid life-support under circumstances such as Nancy's would still need to know that such things as living wills exist and how to execute one. Often legal help would be necessary (*Cruzan v. Director*, 1990).

Congress moved to improve patient awareness of advance directives through the passage of the Patient Self-Determination Act (PSDA). It was passed as part of the Omnibus Budget Reconciliation Act (OBRA) of 1990 and most of its provisions took effect in December 1991. The Act addressed the rights of patients to make autonomous decisions concerning their medical care, and it strove to ensure that Americans were educated about their options prior to a medical crisis. Those health care organizations that received Medicare or Medicaid funds were required to educate their beneficiaries about advance directives and give these beneficiaries the chance to execute advance directives if they chose to do so. (Zucker, 1999)

The Military Health System

The military health system (MHS) has followed the provisions of the Patient Self Determination Act for many years. This was not because the MHS was required to comply by statute; it was not. Until the institution of TRICARE for Life, the MHS was prohibited from accepting either Medicare or Medicaid funds, the trigger for requiring compliance. (TRICARE Management Activity, 2001) Compliance with the provisions of the Patient Self Determination Act is the result of the Defense Department's requirement for medical treatment facilities to be

accredited by the Joint Commission on the Accreditation of Health Care Organizations (JCAHO), hereafter referred to as the Joint Commission. The Department of Defense (DoD) requires "all fixed hospitals and free-standing ambulatory clinics, including those providing care to DoD beneficiaries under various managed care support contracts" to be accredited by the Joint Commission. (Department of Defense, 1995, section 4.1.2)

The Joint Commission details its standards for accreditation and updates these standards each year. The specific requirements that each health care facility must meet to earn accreditation are found in the current edition of Joint Commission's accreditation manual for the specific type of medical facility. As noted by the 1995 Health and Human Services Report on the early implementation of the PSDA, the Joint Commission has had a long history of requiring facilities to identify and honor advance directives and had incorporated the requirements of the PSDA in 1992. The 2004 Joint Commission standard that addresses advance directives is Standard R.1.2.80. This standard evaluates how the organization addresses the wishes of the patient relating to end-of-life decisions. The Joint Commission specifies as part of the standard that accredited hospitals comply with the state laws that address living wills and durable powers of attorney. (United States, 1995, Joint Commission on Accreditation of Healthcare Organizations, 2003)

To ensure that the medical facilities within the military health system are able to uphold the Joint Commission's standards, regulations at every level attempt to protect the ability of patients to make autonomous health care decisions. Department of Defense Directive 6000.14 (DODD 6000.14) signed on July 30, 1998, states that a patient has a right to prepare an advance directive if he or she chooses to do so, and the signed advance directive will be incorporated into the patient's medical record. It is the provider's duty to discuss with a patient the different types

of advance directives and to "abide by all decisions made by their patients and/or their designated representatives" (Department of Defense, 1998, July 30 section 4.4.2). Of course, there are times when a provider fundamentally disagrees with a patient's treatment desires. such situations are addressed in DoDD 6000.14. It states, "A provider who disagrees with a patient's wishes as a matter of conscience should arrange for transfer of care to another qualified provider willing to proceed according to the patient's wishes within the limits of the law and medical ethics" (Department of Defense, 1998, section 4.4.2).

In support of the DoD's Patient Bill or Rights and Responsibilities (DODD 6000.14), each uniformed service has developed its own policy supporting a patient's right to execute an advance directive and to include it in the patient's medical record. (Department of the Army, 2002, Navy Bureau of Medicine & Surgery, 2001, Department of the Air Force, 2003)

In the past, lawmakers were concerned that because military members and their families often relocate (as part of military duty requirements) an advance directive might not be recognized as valid in a state other than the one in which it had be executed. As a result, the medical advance directives of military members and other beneficiaries have been given portability under federal law. (10 U.S.C. 1044c)

The medical advance directives of military members and other beneficiaries are exempt from state requirements of form and are designed to be recognized in any state as if they had been executed in that state. This ability ensures that military personnel and their families will not have their wishes ignored because an advance directive is not in a particular format dictated by state law. (10 U.S.C. 1044c) This provision may well have been designed to solve a non-existent problem, as states do reciprocally recognize advance directives written in other states. (American Bar Association, 2004, Sabatino, 2003)

Navy Guidance

The Department of Defense's Patients Bill of Rights and Responsibilities has given each adult beneficiary to the right to include his or her advance directive in his or her medical record. Still, each individual service has the responsibility of ensuring that the advance directive is filed in the medical treatment record. For the United States Navy, the reference that governs the location of forms used in medical treatment records is Chapter 16 of the Manual of the Medical Department (MANMED). The MANMED specifies that living wills and medical powers of attorney will be filed in the outpatient treatment record in section 3, also known as the administrative section; or on the left hand side of the inpatient record folder. (Navy Bureau of Medicine & Surgery, 2001, December 14) This means there is more than one place to file a patient's advance directive.

The current versions of the Navy's instructions concerning do not resuscitate orders, determination of brain death, and informed consent are dated but remain in effect. The age of these instructions is an area for concern as all three of them predate the Patient Self-Determination Act (Naval Medical Command, 1983, Naval Bureau of Medicine & Surgery, 1974, Naval Medical Command, 1988)

Naval Hospital Bremerton

Naval Hospital Bremerton has striven to involve patients in all aspects of treatment decisions. In the hospital's instruction addressing the right of patients to participate and direct his or her healthcare decisions, it aspires to provide guidance on patient education concerning advance directives, to offer referral to the Naval Legal Service Office (NLSO) most convenient for him or her to execute an advance directive, and to track patient preferences in the inpatient record. (Naval Hospital Bremerton, 2002)

The Naval Hospital Instruction 6000.7D, Patient Right to Participate in and Direct Healthcare Decisions, dated 1 October 2002, includes a form designated as NHBREM 6000/39 Advance Directive and Patient Rights Acknowledgment. (Appendix A) This form is written at a 9.9 grade level using the Flesch-Kincaid scale. The current form has three major sections. Section A of NHBREM 6000/39 was designed to ask the patient, at the time of admission, if he or she had an advance directive and to get a copy of the advance directive, if possible. Because a patient may not be able to answer the questions him or herself, section B of the Naval Hospital Bremerton 6000/39 provides space to note the treatment preferences of the patient or his or her surrogate. Section C of the form is meant to be used by the provider during his conversation with the patient or his or her surrogate at the time of admission. Space is provided to clarify the specifics of any advance directive; to provide the patient with the opportunity to obtain an advance directive; and to capture the patient's treatment preferences at the time of the advance directive discussion, if the patient does not wish to get an advance directive. This form is printed on blue paper and is commonly known as the *blue form* within Naval Hospital Bremerton. (Naval Hospital Bremerton, 2002, October 1)

The prior version of the form had the same numerical designation as the *blue form*, but differed in its composition. (Appendix B) Printed on green paper, it had only two sections. This form was written at a 10.7 grade level using the Flesch-Kincaid scale. Unlike the *blue form*, there was no place for the provider to note any discussion about an advance directive or to transcribe a patient's treatment desires in the absence of a formal directive. This version of the form was commonly referred to as the *green form* and was superceded, in late 2002, by the *blue form* assigned the same number.

Conditions that Prompted the Study

Military hospitals, like their civilian counterparts, face life and death decisions daily. It is in the attempt to provide the best standard of care possible that DoD has continually striven for military medical treatment facilities to deliver quality health care. This is why the DoD requires its medical treatment facilities to earn accreditation from the Joint Commission. (DoD, 1995)

The Joint Commission conducts regular surveys and has outlined the areas to be inspected for compliance, along with standards to be met in each of those areas. Previously, the Joint Commission's surveys were scheduled every 3 years and used a scoring system that provided some leeway in how the organization was scored overall. The overall score that the Joint Commission assigned to a medical facility would then be used to determine which level of accreditation, if any, would be granted.

Beginning in 2004, the facilities have been surveyed under a new set of standards and using a new scoring system. This change in the accreditation process is known collectively as "Shared Visions –New Pathways." The new surveys are intended to reduce redundancy, continuously improve quality, and increase sustained compliance with Joint Commission standards. Each individual standard is comprised of elements of performance which will be assigned a compliance score of zero, one, or two. Two would be a score indicating satisfactory compliance, one would be partial compliance, and zero would indicate no compliance. The elements of performance scores will be aggregated to determine standards compliance.

Any element of performance that receives a score of zero will result in the standard being scored as non-compliant. Accreditation will not be granted to a healthcare organization, if there is any standard that has been scored as non-compliant, until sustained compliance can be demonstrated. A healthcare organization will demonstrate its sustained compliance from January

2004 through June 2005 by submitting Evidence of Standards Compliance within 90 days of the onsite survey for approval. Four months after Evidence of Standards Compliance is approved, the organization will submit data on its 'Measure of Success' to demonstrate ongoing compliance (Joint Commission on Accreditation of Healthcare Organizations, 2003).

The 2004 Joint Commission standard that addresses advance directives is Standard R.1.2.80 (The organization addresses the wishes of the patient relating to end of life decisions.) The Naval Hospital Bremerton was surveyed by the Joint Commission in August of 2004 under these new standards. In order to ensure continuous preparedness for the future Joint Commission surveys, the manner in which the Naval Hospital addresses advance directives will need evaluation on several levels.

The need to evaluate the Naval Hospital's process is not just due to the new survey scoring system; it is also due to a different method of evaluating an organization prior to scoring its performance. The new method is referred to as the tracer method. It involves following selected patients through the facility and examining each part of the patient's experience. This presents a challenge because it will allow the survey team to more thoroughly examine each service within the organization from a patient's perspective. (Joint Commission on Accreditation of Healthcare Organizations, 2003)

Merely having a policy on advance directives will no longer be enough. The Naval Hospital will have to show that it has a viable way to protect patient autonomy. A patient must be offered information on the types of advance directives available and how to obtain one if he or she chooses to do so. Advance directives, if executed, must be clearly identified, accessible to the treatment team, and be acted upon by the provider in accordance with hospital's policy.

Research Questions

The identification of advance directives, access to pre-existing advance directives, and compliance with advance directives at Naval Hospital Bremerton was the proposed focus of this study. Three basic questions need to be answered. The first question is how does Naval Hospital Bremerton identify if a patient has an advance directive? How does the hospital access previously executed advance directives? Lastly, if a patient has an advance directive, how well does the hospital follow it?

Literature Review

Advance directives strive to protect patient autonomy and ease the decision making process when medical crises occur. "Living Wills and DPAs (Durable Powers of Attorney) protect autonomy interests and may reduce stress for families and health professionals who fear making the wrong decision..." (Beauchamp & Childress, 2001, p.153).

Although advance directives have been considered a good way to express treatment preferences, few people actually execute them or leave explicit instructions. This was mentioned in the *Cruzan* case and has continued to be the situation in the intervening years. (Beauchamp & Childress, 2001) When the General Accounting Office evaluated the Patient Self Determination Act in 1995, it found that although providers were giving information on advance directives to patients, less than 25 percent of the patients chose to execute an advance directive. (United States, 1995)

Living wills give patients the opportunity to explain their treatment preferences prior to the need to make life and death decisions. Although these instruments should provide a clear indication of what sort of medical interventions a patient wants, it is usually more effective if a patient discusses his or her views concerning medical treatment with both his or her family and

provider before the need to invoke an advance directive arises. Without candid discussions, ambiguity can make it difficult to both clearly identify or meet a patient's treatment expectations. This is one of the pitfalls of advance care planning highlighted in the American Medical Association Ethics Standards Group's information for physicians, "Vague statements can be dangerously misleading. Be sure of patient preferences if they do not seem clear to you or to the proxy" (American Medical Association, 2000, November). A living will allows a patient to communicate his or her desires and needs to providers when he or she is no longer able to do so. There is no substitute for a frank discussion of medical treatment options and patient preferences to ensure that a living will is interpreted by the healthcare team as intended by an informed patient.

An informed patient is a patient who understands what his or her treatment choices entail. The use of advance directives is firmly rooted in the concept of informed consent. The elements of informed consent are very straight forward: competence, voluntariness, disclosure of the pertinent information, understanding of potential choices, and a decision either in favor or against a particular course of action. (Beauchamp & Childress, 2001) When a patient is in distress, these elements may be compromised, and a patient's comprehension of the material presented may often be overestimated.

Patient education about choices is vital, but the forms and brochures that we use may not be accomplishing what the healthcare team wants. As Evelyn Fisher wrote when summarizing the research on patient's comprehension of materials;

> Reading comprehension tends to be lower than word recognition, and the educational grade completed tends to be higher than the individuals' reading level. Educational materials for patients generally are written at the ninth-grade level or higher. Individuals

who report an illness or disability tend to have lower literacy scores than individuals who do not report an illness or disability (Fisher, 1999, p. 59).

The impact of reading comprehension cannot be underestimated. As Michael Aldridge wrote, "If patients cannot read educational materials then there is little hope of them using or understanding the information" (Aldridge, 2004, p.373). The potential difficulty understanding written materials means that the personal interaction with the healthcare team takes on greater importance.

While it is preferable to have patients execute advance directives while in an outpatient setting, many providers are not able to spend much time discussing advance directives or treatment preferences with their patients. In a 1994 study, reported in the *Annals of Internal Medicine*, the average time a provider and patient discussed advance directives during an appointment was 5.6 minutes; physicians spoke for an average of 3.9 minutes. (Tulsky, Fischer, Rose, & Arnold, 1998)

The brevity of medical appointments may not be the primary reason so little attention is given to advance directives. Other very human factors may influence the length of discussions. For instance, both patients and providers may be reluctant to discuss end of life planning because it may seem that by doing so they are giving up on treatment. Patients may have unrealistically optimistic expectations or may not want to face their mortality. There may also be cultural biases on the part of the patient or provider against the use of advance directives. (Maxfield, Pohl, & Colling, 2003, Dupree, 2001)

Another impediment to the discussion of advance directives is the perception that only the ill and elderly really need these tools. Studies have found that advance directives are more likely to be executed by the elderly who have been asked about their end-of-life preferences.

(Gordon & Shade, 1999) The elderly are not, however the only people who could benefit from advance directives. As demonstrated by the case of Nancy Cruzan in 1983 and more recently by that of Terri Schiavo, the lack of an advance directive can mean that families face years embroiled in legal proceedings. Both Nancy Cruzan and Terri Schiavo were young, seemingly healthy, and neither woman probably ever thought about executing either a living will or a durable power of attorney. (Church, 2000, Sommer, 2003, Dresser, 2004)

Neither Nancy Cruzan nor Terri Schiavo had an advance directive, but even some people who have executed living wills or durable powers of attorney have not had them followed. A part of the problem has revolved around getting advance directives from the outpatient setting into the acute treatment setting. A study published in 1995, by the Journal of the American Medical Association, said that the clerical staff missed 39% of the advance directives of competent patients upon admission; advance directives on incompetent patients were missed 74% of the time. (Morrison, Olson, Mertz, & Meier, 1995) This inability to get to an advance directive when it is needed has prompted some innovative solutions. Among these are the use of bracelets on patients who do not want to be resuscitated, the use of tattoos, and the listing of advance directives in secure sites on the Internet. (Las Vegas Review-Journal, 2001, MedicAlert Foundation International, n. d, Choices Bank, 2002, Fleming & Curti, 1995)

Purpose

The purpose of this study was to determine how well the Naval Hospital Bremerton did at identifying, accessing, and applying advance directives for adult inpatients who were hospitalized during fiscal year 2003.

Methods and Procedures

The study model was a retrospective, exploratory review of inpatient records for adult patients admitted for longer than 24 hours to the Naval Hospital Bremerton between October 1, 2002 and September 30, 2003. Only records of patients who were 18 years old or over were included in this analysis. The Composite Heath Care System was queried to identify patients that would meet study parameters. There were 1,981 individual inpatient records identified. All but five of the charts were found in the Naval Hospital Bremerton's inpatient records department and hospital archives. The 1,976 inpatient charts were reviewed for the presence of the Naval Hospital Bremerton's current blue advance directive form or its green predecessor, and other types of documentation surrounding advance directive discussions.

Each chart was reviewed manually and the information from the record was recorded in the Excel spreadsheet. Patient gender, beneficiary category, and information concerning the patient and provider interaction was transcribed by the researcher. Responses to questions on the two versions of the hospital's advance directive query form were entered in separate fields. The information gathered from each record was examined collectively with other information from the same patient's record. This technique provided for a longitudinal analysis of the agreement or disagreement between provider and patient entries. Because the Naval Hospital has been conducting focused record reviews that have included examination of advance directives for the inpatient population, this review permitted an analysis of the validly and reliability of the current process.

Expected Findings and Utility of Results

The author reviewed all of the decedent records maintained in the Naval Hospital's Patient Administration department in August 2003. The decedent records were purged less than a

month after the author checked aboard, and the overwhelming majority of records did not have advance directives filed in them. Of the records of 29 individuals whose decedent records were on file for the year 2000, four had advance directives on file. Of the 44 individuals who had died since the year 2000, none had advance directives in their decedent file. The lack of advance directives could be due to a change in the information maintained in a decedent file, or it could be due to other factors that are not evident on first blush.

The information that has been gleaned from the ongoing record reviews would seem to indicate a positive picture. The focused reviews are small in scope, but report that advance directives have been discussed with patients more than 90% of the time. Although hospital reviews of advance directives have been ongoing, it is possible that the positive numbers reported in the record reviews reflect the presence of a provider signature on the Naval Hospital Bremerton's advance directive form and little else. The number of patients who either had a conversation with their provider concerning advance directives or the presence of an advance directive in the patient's chart may not have been well captured.

Findings

Of the 1,976 records in the study, there were 39 complete advance directives and one incomplete medical advance directive found. Table 1 shows the age and beneficiary category of the population whose records were reviewed.

Table 1

Patients by Beneficiary Category (n=1,976 records)

Patients Beneficiary Category	Low Age	High Age	Median Age	Mode	Mean	SD	Total
Active Duty	18	60	24	23	27.27	8.03	338
Child of Active Duty	18	21	19	18	19.19	1.05	16
Child of Deceased Retired Member	61	51	61	N/A	61.00	N/A	1
Child of Retired Member	18	42	20	22	20.78	4.15	32
Emergency Care Patient	28	56	43	N/A	42.50	14.55	4
Former Service member maternity	21	25	21	21	22.00	1.73	5
Parent of Active Duty	57	76	69.5	76	67.83	8.33	6
Reserve Member	49	58	53.5	N/A	53.50	6.36	2
Resource Sharing Patient	35	46	40.5	N/A	40.50	7.78	2
Retired Member	26	96	64.5	62	66.22	13.00	413
Spouse of Active Duty	18	51	26	21	27.58	6.43	793
Spouse of Retired Member	20	91	58.5	52	59.07	14.72	306
Spouse of Deceased Active Duty	47	87	58	N/A	64.00	20.66	2
Spouse of Deceased Retired Member	34	95	74	63	73.00	12.73	55

Table 2 shows the beneficiary category of the patients who had advance directives in their inpatient record. The records were examined manually, and there was no specific means employed in the records used to alert the healthcare team to the presence of an advance directive other than the information on the hospital's advance directive query form. The majority, 17 of

the 39 advance directives found, belonged to retired members. Ten advance directives belonged to the spouses of retired members, and seven advance directives were in the charts of widows of retired members. The remainder of the medical advance directives found belonged to an active duty member, a child of a deceased retiree, and a child of a retiree. Both children were over the age of 18 and were properly designated beneficiaries.

Table 2

Patients with Advance Directive Present in Record (n=1,976)

Beneficiary Category	Gender	
	M	**F**
Active Duty Member	0	1
Child of Deceased Retired Member	1	0
Child of Retired Member	0	1
Retired Member	16	1
Spouse of AD	0	2
Spouse of Retiree	0	10
Surviving Spouse of Deceased Retired Member	0	7

In the records reviewed in this study, an overwhelming majority of the records with an advance directive had a durable power of attorney on file. In total, 33 of 39 records with an advance directive had a durable power of attorney for healthcare. In 21 of these records, a durable power of attorney was the only form of advance directive on file. Twelve records had both a durable power of attorney for health care and a living will. There were six records where

living wills were the only advance directive present. Of all of the records with advance directives, only four had the advance directives prepared by a military legal services office.

One finding of note was the presence of three financial advance directives on file. These financial documents were filed as if they were medical advance directives even though there was nothing contained within them addressing medical decision-making. Two of the financial advance directives were found in the records of male military retirees while the third was in the record of the spouse of a retired member.

In addition to 39 advance directives found during the study, there were 374 patients who claimed to have an advance directive but no such document was found in their corresponding inpatient record. Table 3 shows the distribution of the patients who claimed to have executed an advance directive in the past. As with other studies, the greatest number of patients who said that they had an advance directive were in the older segments of the population surveyed.

Table 3

Patients Who Claim to Have a Directive (n=1976 records)

Beneficiary Category	Gender	
	Male	Female
Active Duty	15	16
Child of Active Duty	0	1
Emergency Care Patient	1	0
Parent of Active Duty	0	1
Retired Member	139	9
Spouse of AD	1	86
Spouse of Retiree	0	85
Surviving Spouse of Deceased Retiree	0	19
USTF Enrollee	1	0

Of 374 patients who claimed to have executed an advance directive, 217 were female and 157 male. Male retired military members comprised the largest group (124) of male respondents claiming to have an advance directive. Spouses of active duty members made up the largest group (85) of females who claimed to have advance directives. Spouses of retired military members were the second largest female group, with 74 individuals claiming they had advance directives. Sixteen male active duty members and fifteen female active duty members indicated that they had an advance directive, although there was nothing on file in their patient record.

Another sizable group was the widows of retired members; fourteen indicated that they had executed advance directives but no corresponding directive was found.

The desire to obtain an advance directive was also well documented. Three hundred and ninety-two patients stated that they did not have an advance directive but wanted to execute one. Of these, 194 were female spouses of active duty members. Male retirees and active duty females were the next largest group wanting advance directives, numbering 56 and 50 patients respectively. Providers referred 170 of these patients to the Navy Legal Service Office.

The Naval Hospital Bremerton's advance directive query forms were found in 1,923 of the records reviewed. The *blue form* was found in 1,491 of the records reviewed while the *green form* was found in 438. One record had both forms present. Fifty-three records were found not to have either the green or blue versions of the Naval Hospital form 6000/39 or any other documentation that an advance directive query had occurred upon admission.

Where the green advance directive form was used during the admissions process, the discussion between patient and provider was not routinely documented. This form was designed to be reviewed and initialed by the patient with the admissions clerk providing documentation if the patient was not able to complete the form for any reason. With the addition of provider input on the blue form, the presence or absence of provider participation in the advance directive discussions became easier to identify.

Among the records that contained the *blue form*, there were 996 records where the provider clearly discussed the subject with the patient and signed the form. Another 344 records with the *blue form* contained no further documentation of an advance directive discussion than the providers' signature at the bottom of the form. There were also 24 records that contained a

provider entry that stated that advance directives were not discussed. Twenty-three of which were from a single department.

The reviewer found that the provider's documentation was consistent with the patient's written desires in 822 of the 1,976 records reviewed. There was no documentation of the provider discussing advance directives in 895 of the records; however, 438 of these records contained the *green form* that did not permit provider documentation. In the space provided to summarize the patient's treatment desires, i.e. section C of the *blue form*, 1,083 records had no entry outlining what the patient wanted.

Sixty-eight patients, 46 of them admitted for labor and delivery, were described as being in such pain that advance directives could not be discussed at admission. Thirty-four of these patients were referred to the Navy Legal Service Office to formulate an advance directive in the future, indicating some discussion either took place after the initial admission.

There were 84 patients whose written input conflicted with the provider's documentation. Providers indicated that 71 of the patients did not want an advance directive after the patient had indicated that he or she either had an advance directive or wanted to execute one. This conflict could be for a number of reasons from a documentation error to evidence that the patient had changed his or her mind.

Discussion

The percentage of patients that choose to execute an advance directive has never been large. By some accounts between four and twenty-four percent of patients feel compelled to formally document their end of life choices. (Carney & Morrison, 1997, 65) The number of advance directives that were found in the inpatient records was below two percent. However, the presence of both versions of the Naval Hospital Bremerton Form 6000/39 indicates that the

patients are being consistently asked if they have advance directives. 18.88% of our patients reporting that they have advance directives. The question remains, why are there so few advance directives on file?

One explanation of the disparity between the number of advance directives on file and the number of advance directives claimed could be that previously executed advance directives are not readily accessible when admitting a patient. In the study done by Dr. Morrison and his colleagues, it was discovered that only about 40 percent of the advance directives executed by patients were correctly identified and included in the patient's chart. (Morrison, Olson, Mertz, & Meier, 1995) It is certainly possible that some of the individuals in this study had advance directives that were not included in the inpatient records at the time of admission.

The study found that 33 of the 39 records that had advance directives on file contained a durable power of attorney for healthcare. The number of records with a durable power of attorney may be due to availability of brochures entitled, "Who Will Decide if You Can't" (Washington State Medical Association, 1996) which allows a patient to write in the name of his or her surrogate on a form contained within it. These brochures were purchased by the Naval Hospital from the Washington State Medical Association, are can be found in patient waiting areas throughout the facility, and the brochures are available through the hospital admissions office.

Perhaps, patient confusion may also play a role in explaining the difference between the number of patients who claim to have an advance directive and those patients with an advance directive filed in their health record. A possible source of confusion could be that the terms advance directive or power of attorney are not exclusive to healthcare. In preparation for deployment, a military member may be advised to ensure that his or her spouse has a power of

attorney to avoid potential difficulties. Communication between the patient and provider is the only way to verify if the term "advance directive" means the same thing to both parties. Certainly, a misunderstanding of what the term means in could be one reason that three financial advance directives were found filed in the medical records examined during this study.

Although the Joint Commission requires that medical facilities have their personnel ask about advance directives at the time of admission, this is a time of great stress and patients should have the opportunity to consider their options without feeling pressured. A basic tenant of informed decision-making is that the patient should be able to, in consultation with the healthcare team, make decisions freely. (Beauchamp & Childress, 2001, Bialk, 2004, Carney & Morrison, 1997) The inpatient setting may be the wrong place to initiate the dialogue on advance directives. If the discussion of advance directives was begun in the outpatient setting, especially during a non-emergent encounter, the opportunity to execute an advance directive and to identify existing directives on file would improve.

In this study, some patients were in such pain at the time of admission that the providers felt that the discussion regarding advance directive could not go forward. The extent to which advance directives were addressed prior to an admission is unknown, but it may provide fertile ground for future research. Conducting the advance directive discussion in a non-threatening environment, before an admission, may provide a very different picture of how many patients either possess or want to execute advance medical directives. (Bialk, 2004, Carney & Morrison, 1997)

Discussions begun in the outpatient setting would allow a patient to better identify which options presented to him or her will best meet individual treatment goals. Physicians and other care providers will favor certain courses of treatment based on their experience and medical

training. A patient who is not facing a crisis will be better able to decide if the healthcare team's preferences are appropriate for his or her individual situation. According to Peppin, a provider's strong feelings concerning a particular course of treatment could be used to persuade patients and manipulate the consent process. Factors such as the patient's age, limitations on resources, concerns over the patient's quality of life, and futility might guide a provider's discussion of advance directives. Providers strive to keep the patient's best interests in mind, but each provider must remember that it is the patient's choice to either pursue an advance directive or not, and that the patient's choices may differ from those of the healthcare team. (Peppin, 1995)

Communicating the need to have the advance directive available for discussion is another area that should be explored. The large number of people who said that they had an advance directive may be inflated. Is the patient aware that he or she has to bring the advance directive to the hospital in order to have it included in his or her medical record? Patients may not have been told to do so before admission.

Patient education is important. Providing patients with written information may not be enough to help them understand the differences between a durable power of attorney for healthcare and a living will. In the past, the Naval Hospital Bremerton offered classes on advance directives; that is no longer the case. Reinstituting such classes would provide patients the opportunity to learn what an advance medical directive is, who should know about these directives, and where copies should be filed.

Accessing advance directives can be challenging for both the patient and the healthcare team. The majority of advance directives are not usually executed in the hospital. This means that the likelihood that an advance directive will end up back at the hospital is less than if the hospital owned the process. The local Navy Legal Services Office (NLSO) is on a separate base,

so if a patient uses the services of the NLSO to execute an advance directive, he or she is responsible for bringing their advance directive to the hospital for filing. While it is appropriate for the patient to decide if he or she wants their advance directive on file, the advance directive may never make it into the proper medical record. This is so because the patient must carry a directive from the NLSO to the Naval Hospital and the a patient is often unaware that there is more than one type of medical record at the Naval Hospital.

Technology could provide a secure means of allowing advance directives to travel from NLSO to the hospital and be available even if the medical record is not. One option would be to use a secure website that would serve as a repository for advance directives. This would improve access to an advance directive and provide a timely way to locate it. By improving access to advance directives, online repositories have been becoming a more attractive option for both patients and providers. There are multiple systems available, and the concept of governmental use of online repositories is becoming a more viable alternative. For instance, the state governments of Montana and Hawaii have embraced online repositories as a mean to facilitate access to a patient's advance directive. Some of these repositories charge providers for access others charge the patient for the privilege of listing his or her advance directive. (Choices Bank, 2002, MedicAlert Foundation International)

A similar option could be employed using the integrated clinical database (ICDB) at the Naval Hospital Bremerton. The database works with the Composite Health Care System and provides a portal to upload images of documents (in Adobe Acrobat format). Advance directives could either be scanned manually or using a secure internet fax service into the Adobe Acrobat format. The Integrated Clinical Database could then provide the means to link an advance directive to a patient independent of the paper record. The system also provides for comments

describing treatment preferences to be entered with the document. If the patient should choose to revoke the advance directive, the document can be deleted from the system.

Aside from the difficulty in accessing advance directives, many providers have taken issue with the fact that patients with living wills often have the document written either in extremely broad terms or with such a narrow focus as to make the directive useless. (Bialk, 2004) The literature recommends discussing treatment goals with the patient. By understanding what the patient sees as the desired outcome, the provider can better meet those expectations and assist the patient to incorporate them into the advance directive. (Tulsky, Fischer, Rose, & Arnold, 1998)

The hospital's executive leadership can also have a direct impact on the process of identifying advance directives and honoring patient treatment preferences. Leadership sets the tone within the organization. If patient autonomy is important to the leadership, it will be more important to the organization as a whole. Cooney, Landers, and Williams discussed the importance of having leadership behind efforts to recognize advance directives and improve end-of-life care. The authors reported that when leaders were uncomfortable with end-of-life care, they would give verbal support but would not make program improvement a priority. Conversely, leaders who understood and appreciated end-of-life issues were likely to foster continuous improvement. (Cooney, Landers, & Williams, 2002)

Suggested strategies for leaders to encourage continuous improvement include examining aggregate data on end-of-life issues, evaluating staff education and patient outreach programs that teach about advance directives, and reviewing compliance programs regularly. Cooney, Landers, and Williams reported, "Few hospitals knew the proportion of patients with advance

directives and fewer still enacted the system changes necessary to realize their full potential" (Cooney et al., 2002, p. 28).

Conclusions and Recommendations

This study identified 39 records with advance directives in a sample group of 1,976 patient records. Of those 39 records, 33 had a durable power of attorney for healthcare; 18 records had a living will. Twelve records had both a living will and a durable power of attorney. Standard procedure required personnel of the Naval Hospital Bremerton use the hospital's Form 6600/39 to ask for copies of patients advance directives at the time of admission. Once the Naval Hospital Bremerton Form 6600/39 was completed, the documentation in the record indicates that the healthcare team behaved in a manner consistent with the patient's wishes.

The study identified 374 patients who said that they had an advance directive, but only 39e records had advance directives on file. Three hundred ninety two additional patients did not have an advance directive but were interested in pursuing one. These findings indicate that an opportunity to improve the process of executing, recognizing, and accessing advance directives at the Naval Hospital Bremerton does exist.

There are a number of actions that would make the most of the opportunities for improvement highlighted by the study. First, among these actions is to revive the advance directive classes at the Naval Hospital. Patients and staff could both benefit from learning more about the advance directive options available. Reestablishing the classes would also present an opportunity for personnel from the Naval Legal Service Office and the Naval Hospital staff to build a stronger relationship.

These advance directive classes could be incorporated into pre-deployment preparation, community outreach, and hospice education. By establishing *an electronic clinic* in Composite

Health Care System, it would also be possible to track class attendance and demonstrate continuing compliance with the applicable Joint Commission standards.

Secondly, the Naval Hospital Bremerton Form 6000/39 should be re-evaluated and redesigned. This form has questions that require more than one response and is printed in 10-12 point type. This can be both confusing to the patient and difficult to read. Another concern is that the reading level may be too high. The current form has a Flesch-Kincaid grade level of 9.9, and most of the literature recommends that patient materials not be written above 8.0 grade level. (Aldridge, 2004)

Thirdly, personnel need to work to improve identification of and access to patient advance directives. Naval Hospital Bremerton Form 6000/39 should indicate whether a patient has been asked if he or she has an advance directive, but using a sticker on the form to indicate when a patient actually has an advance directive would help to remind the healthcare team to review it with the patient. A similar sticker could be used on the administrative section divider in the outpatient chart. This would prompt the provider to discuss with the patient his or her preferences concerning an advance directive, and it would make it easier for the records staff to identify which volume of the patient record has the advance directive filed in it.

Because there are times when the provider has to know what a patient wants and the medical record is not available, the Naval Hospital should investigate the integration of a scanned copy of a patient's advance directive into the integrated clinical database.

A patient's advance directive could be uploaded after it is converted to a file format that the integrated clinical database would accept. This could be accomplished a number of ways. One way is to have a scanner available within the hospital that could convert advance directives

to an Adobe Acrobat file format, save the file, and then import the file into integrated clinical database.

Another option would be to utilize an electronic fax service that would both convert and secure the advance directive information during transmission. The cost of using an electronic fax service will be higher, but the information would be protected in accordance with current privacy law and could be uploaded by personnel from anywhere in the hospital. Madigan Army Medical Center (MAMC) is currently using an electronic fax service to receive results from the regional Tricare contractor. MAMC's Referral Coordination Center uploads these results and integrates them into the patient record. A minor modification of the process would be all that is required to make patient advance directives accessible to both the inpatient and outpatient staff. There is also an option that would allow a directive to be removed if the patient decided to revoke it. An added benefit of this process, because MAMC and the Naval Hospital share the same computer server for the integrated clinical database, the advance directive would be available to MAMC staff if a patient were transported to MAMC for care. (J2 Global Communications, 2004)

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Sample of NAVHOSPBREMINST 6000.7D (The *Blue Form*) Appendix A

NAVHOSPBREMINST 6000.7D
1 Oct 02

ADVANCE DIRECTIVE AND PATIENT RIGHTS ACKNOWLEDGMENT

Name: _____ SSN: _____

Instructions: The patient or their surrogate is to read and initial the appropriate lines of section A and sign and date in the appropriate space. The admissions clerk is to fill out section B, if necessary, and also sign and date in the appropriate space. The provider is to complete section C and sign and date at the bottom of the sheet. If a Resident fills out section C, then a Staff co-signature is required.

Section A

1. I have been informed of patient's rights and responsibilities. ___
2. I have been provided written materials on Organ Donations and Advance Directives (Living Wills and Durable Powers of Attorney for Health Care). ___
3. I have been informed of my rights to prepare Advance Directives at any time and I understand that I am not required to have an Advance Directive in order to receive treatment ___
4. I HAVE / HAVE NOT (circle one) prepared an Advance Directive and it IS / IS NOT (circle one) attached. ___
5. I DO / DO NOT (circle one) wish to prepare an Advance Directive. ___
6. I understand that the terms of any Advance Directive that I have prepared will be followed by the health care facility and my caregivers to the extent permitted by ethics and law. To facilitate compliance with my Advance Directive, if I have one, I realize that this facility needs a copy of any Advance Directive within 24 hours of admission. If I am unable to obtain a copy, I understand that I may express its content to my health care provider and/or create a new Advance Directive. ___

_____ _____

Patient or Surrogate Signature Date

Section B

The patient or their surrogate was not able to complete this form at the time of admission due to the following reasons:_____

_____

_____

_____

_____ _____

Admission's signature Date

Section C

Circle the appropriate statement below and document details as indicated.

1. The patient does not have an Advance Directive and does not wish to prepare one.
2. The patient does not have an Advance Directive but wishes to formulate one. Referral is to be offered to the Navy Legal Service Office Northwest. A synopsis of the patient's wishes is detailed below.
3. The patient has an Advance Directive but we do not have a copy and the essence of its content is outlined below.
4. The patient has an Advance Directive and a copy has been provided and reviewed.

_____

_____

_____

_____ _____

Providers Signature/Co-Signature Date NHBREM 6000/39

Sample of NAVHOSPBREMINST 6000.7D (The *Green Form*) Appendix B

NAVHOSPBREMINST 6000. 7c
3 Nov00

ADVANCE DIRECTIVE AND PATIENT RIGHTS ACKNOWLEDGMENT

Name:_____ SSN:_____

Please Read the following and Initial the Following Statements:

1. I have been informed of my patient rights and responsibilities. ____
2. I have been provided written materials about Organ Donations. ____
3. I have been provided written materials about Advance Directives. ____
4 I have been informed of my rights to formulate Advance Directives at any time ____
5. I understand (that I am not required to have an Advanced Directive in order to receive treatment at this health care facility. ____
6 I understand that the terms of any Advance Directive that I have executed will be followed by the health care facility and my caregivers to the extent permitted by law. To facilitate compliance with my Advance Directive. I realize that this facility needs a copy within 24 hours of my admission. If unable to obtain a copy, I understand that I may execute (orally or in writing) another Advance Directive. ____
7 I HAVE / HAVE NOT executed an Advanced Directive and IT IS / IS NOT attached. ____
8. I DO / DO NOT wish to execute an Advanced Directive ____

COMPLETED BY ADMISSIONS STAFF WHEN PATIENT IS UNAVAILABLE AT THE TIME OF ADMISSION

The patient was unable to complete this form at the time of admission due to the following reasons:

_____
_____
_____
_____
_____

NHBREM 6000/39